IN THE UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF GEORGIA
ALBANY DIVISION

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| MICHAEL NEWCOMB and KATHY NEWCOMB, | : NO. 1:15-CV-00080-LJA |
| Plaintiffs | : |
| vs. | : |
| SPRING CREEK COOLER, INC.; SPRING CREEK PRODUCE, LLC; SF FARMS, INC.; SF EXPORTS, INC.; T&L FARMS, INC.; TERRIL SCOTT PROPERTIES, LLC; TERRIL SCOTT FARMS, LLC; WALDINE B. SCOTT FARMS, LLC; EDDIE T. SCOTT FARMS, LLC; TS EQUIPMENT LEASING, LLC; L&W FARMS, LP; TERRIL SCOTT; and JOHN DOE, Name Unknown, Address Unknown | : |
| Defendants | : |

VIDEOTAPE DEPOSITION OF TIMOTHY B. ECKEL, M.D.

Taken in the offices of Timothy Eckel, 1410 Bloom Road, Danville, Pennsylvania, on Wednesday, February 15, 2017, commencing at 9:15 a.m., before Justine Starrick, Registered Professional Reporter, Tim Art, Videographer.

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GALLAGHER REPORTING & VIDEO, LLC
Mill Run Office Center
1275 Glenlivet Drive, Suite 100
Allentown, PA 18106

(610)439-0504/(800)366-2980

Gallagherreporting@verizon.net

APPEARANCES:

THE HELMS LAW FIRM
By: J. JEFFREY HELMS, ESQ.
P.O. Box 537
10 North College Street
Homerville, GA 31634
Jeffhelms@helmslaw.com
-- For the Plaintiffs

GARDNER WILLIS SWEAT PLAIRE & PICKETT
By: MARK L. PICKETT, ESQ.
P.O. Drawer 71788
2408 Westgate Drive
Albany, GA 31707
mark.pickett@gwspplaw.com
-- For the Defendants

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THE VIDEOGRAPHER: The date today is February 15, 2017. The time is 9:15 a.m. This is the videotape deposition of Timothy B. Eckel, M.D., taken in the matter of Michael Newcomb and Kathy Newcomb versus Spring Creek Cooler, Inc., et al, filed in the United States District Court, Middle District of Georgia, Albany Division. Case number 1:15-CV-00080-LJA.

This deposition is being held at 1410 Bloom Road in Danville, Pennsylvania. My name is Tim Art and I am the videographer. I am with Gallagher Reporting and Video. The court reporter is Justine Starrick. At this time will counsel state their appearance for the record after which the court reporter may swear in the deponent.

MR. HELMS: Jeff Helms. I represent the plaintiffs Mr. and Ms. Newcomb in this case.

MR. PICKETT: And I'm Mark Pickett and I represent the defendants in this case.

* * * *

TIMOTHY B. ECKEL, M.D., having been duly sworn, was examined and testified as follows:

* * * *

DIRECT EXAMINATION

* * * *

BY MR. HELMS:

Q. Doctor, I'm Jeff Helms. We met earlier. I represent the Newcombs. We're going to get started. And I just remind you, you're speaking to the jury in South Georgia. So there's the camera over there, and you're up -- where are we located right now?

A. We are in my kitchen of the office at Danville Family Practice, Danville, Pennsylvania, 1410 Bloom Road.

Q. Doctor, you're a medical doctor?

A. Uh-huh.

Q. Do you have a specialty as a medical doctor?

A. I'm a board certified family physician.

Q. Two questions, when you say family physician, what does that mean?

A. I am a member of the specialty in medicine that treats the patient as a whole person from cradle to grave.

Q. Is what we call in south Georgia maybe a family doctor?

A. A family doctor.

Q. Treats the whole gambit of problems that a patient can have?

A. Yes.

Q. From beginning to end of their life if they chose so?

A. Correct.

Q. Is it usual in your practice that you'll treat somebody for the majority of their life?

A. Yeah. Earlier in my career I did obstetrics and have delivered and have second and third generations of patients.

Q. How long have you practiced medicine here in Pennsylvania?

A. I came here to do my residency in family medicine on July 1 of 1976. I finished that residency program June 30, 1979. I opened my solo family medicine practice here July 1, 1979 and have been in solo medical practice since then.

Q. 1979. Help me do the math here. We're in 2017, so almost 40 years?

A. Uh-huh, almost.

Q. All right. And I know we don't want to ask women this, but I'm going to ask you, how old are you, how old are you practicing medicine every day now?

A. I am 67 and a half.

Q. How many patients do you see on a daily basis on average these days?

A. These days it's not as busy as I was, 25, 30 on a busy day. I have seen as many as 45 in a day.

Q. Where did you get your medical training?

A. I went to medical school at Temple University in Philadelphia, and then as I said came to Geisinger and got a residency certification in family medicine at Geisinger Medical Center, Danville, Pennsylvania.

Q. I want to go back to another point that you said you're board certified in family medicine. Can you explain to us what it means to be board certified in the field of medicine?

A. In Pennsylvania you could get a license after one year of post graduate training. That means one year after medical school you can apply for, pass an exam, and be licensed to practice medicine. If you want to be board certified you have to complete, in family medicine, it's a three year program. And then you take an exam, fulfill other qualifications, and then you could use the title ABFM, American Board of Family Medicine after your name, which means you are a specialist that has been recognized by a recognized specialty board in medicine to call yourself a board certified family

doctor.

Q. And to get this board certification you have to take a written test?

A. You've got to take a written test, which mine is coming up for my recertification this year.

Q. And to get it the first time I think -- and that written test, that's a nationwide test?

A. That's a nationwide test. It encompasses a full eight hour day. Initially it was every seven years I had to do it. This last time they've extended it with some extra qualifications that we do it in 10 years.

Q. And the first time you get it do you have to go through an oral presentation also?

A. For family medicine there's not an oral exam.

Q. So is it fair to say that a board certification in family medicine is a certification of a higher status in your practice or a -- how would you describe it?

A. It's just an extra degree to assure the public that they're seeing a physician who has done the extra work to maintain his qualifications in the specialty and be able to diagnose and treat diseases that would be seen in the family practice.

Q. How long did you say you've had this board certification?
A. Ever since I started. I got it initially in '79.
Q. Okay. Here in Danville have you treated a patient by the name of Michael Newcomb?
A. Yes, I have.
Q. Treated him about -- how long have you treated the fellow?
A. Well, I first saw -- I think I saw his wife before I saw Michael. But my first note on him is June 4, 2002.
Q. We're here about an incident that occurred in 2013. So you saw him as a family physician for almost 11 years before the incident here?
A. Correct.
Q. And on average would you see him at least once a year or more often than once a year for that 11 years?
A. Well, he had some other medical problems. And I saw him -- Michael is the kind of guy that wouldn't come in unless he had to. So I saw him once or twice a year, didn't see him for two years, 2004, and then he had his heart attack somewhere along here and I saw him for that. He had some

other health problems. He had some neck pain from his osteoarthritis, and I saw him multiple times closer to this current accident that we're talking about. He had a heart attack in 2010 and I saw him more frequently then.

Q. Just talking about that, even when he had the heart attack in 2010, did he go back to work as a truck driver?

A. Oh, yeah, he went back.

Q. For all the times that you've known Mr. Newcomb before and after this incident has he been a hard worker?

MR. PICKETT: Objection, leading.

Q. How would you describe his work ethic?

A. He has worked all his life, and that's part of the reason why he didn't really keep doctor appointments as much as -- or didn't come in because he was working. He would work 40, 70 hours a week as a long haul trucker.

Q. You've seen him since this incident fairly frequently, I think once a month, since he got hurt in 2013?

A. Yes.

Q. And we're here in 2014 almost four years after the incident. I'm not going to go back

through each and every office visit, but I counted up maybe 40 times that you've seen him since this incident, does that sound about right?

A. Part of the reason is that I have a policy when I put patients on chronic narcotics I see them every month generally, just to keep tabs on them and to make sure there's no abuse.

Q. It's fair to say that you have -- you're going to be able to give the jury a good idea of Mr. Newcomb's condition before this incident and his condition after the incident based on the number of times that you've seen him?

MR. PICKETT: Objection, leading.

A. Yes.

Q. Let me ask you this, Doctor, can you give the jury a good opinion as to Mr. Newcomb's physical overall condition before this incident and after the incident based on the number of times you've seen him as the family treating physician?

A. Yes.

MR. PICKETT: Objection, leading.

A. Yes.

Q. Go ahead.

A. Yes. I've seen the patient before, I saw how he reacted to some of his other major medical

problems, and I saw how he reacted to this accident that we're referring to in this trial.

Q. Now, of course we're here mainly about the injuries that he suffered down on the loading dock in south Georgia in June of 2013. We're going to ask you about treatment of those injuries. But I want you to -- and we're going to talk to you about his condition beforehand. So I think you've got a couple of reports that you prepared at different times?

A. Yes.

Q. Refer to those as you need to, and along the way we'll stop and ask some specific questions about them. But if you could kind of outline to the jury Mr. Newcomb's physical condition before this incident in June of 2013?

A. Before June 20, 2013 I had been following the patient. He had several medical problems before this time. He had chronic cervical spondylosis from his years as a truck driver. That just means arthritis in the neck from bouncing around in the truck. A lot of times you get osteoarthritis. And he had been seen several times because of neck pain.

Q. Here in Danville, this is kind of coal country. Do you treat truck drivers?

A. Oh, yeah, we have a lot of truck drivers.
Q. Is that a condition that you see often?
MR. PICKETT: Objection, leading.
A. Yes.
Q. How often would you see that kind of condition in truck drivers?
A. Well, it's not obviously limited to truck drivers, but I see cervical spondylolysis a lot. A lot of patients have arthritis in the neck and have chronic neck pain, that's fairly common.
Q. What is it about truck driving that may cause that kind of condition?
A. Just the constant bouncing.
Q. What other issues did Mr. Newcomb have?
A. He also had a myocardial infarction, which is a heart attack. He had high blood pressure. He had early signs of diabetes with elevated fasting sugars or glucose. He had high cholesterol. And unfortunately he smoked.
Q. He liked to smoke a cigarette?
A. He smoked every day.
Q. We touched on it before, but despite all that was Mr. Newcomb pretty physically active?
MR. PICKETT: Objection, leading.
Q. Was Mr. Newcomb physically active given

those conditions?

MR. PICKETT: Objection, leading.

Q. How would you describe Mr. Newcomb's physical condition given all those conditions?

A. Well, he was able to, you know, work every day. He was productive. He had some health problems, some of which were related to his lifestyle. But he was functional and he had a family. You know, he was an active, productive member of society.

Q. Now, back in June of 2013 of course he got injured and he came to see you. Can you tell the jury about that first time he came to see you based on this injury that this case is about?

A. Well, he came into my office -- I think the accident was on June the 20th and he came in the following Monday I believe it was, on June 24, 2013. He had stitches on his head. He looked very bad actually. And he told me he had a -- it was crazy, he had an accident down in Georgia and he drove himself home I remember. He said his company said he couldn't leave his truck there.

MR. PICKETT: Objection, hearsay.

Q. This is what the patient said?

A. This is what he told me. It was something

about they wouldn't let him, or he thought they wouldn't let him keep the truck there so he ends up driving it home, which I thought was a little bizarre.

MR. PICKETT: Object to the hearsay.

A. And anyway he came to my office and he had this big gash on the left side of his head with stitches.

Q. I'm going to show you some photographs which I understand you didn't take, but you had a chance to review them this morning, is that right?

A. Yes.

MR. HELMS: These are going to be Plaintiff Exhibit 1 and Plaintiff Exhibit 2. You had a chance to take a look at these.

MR. PICKETT: We're going to object to Plaintiff -- can I see those?

MR. HELMS: Yes.

MR. PICKETT: 1 and 2 in that we had not previously been provided with these before, about 30 minutes ago.

Q. How about showing them to the camera right there. Tell us what they are?

A. One is a picture of a head wound, it looks like Michael Newcomb, I recognize his hair and head.

But the one that I'm looking at now which is to the right shows a recent head injury with blood around the scalp. I don't remember seeing that. I saw the picture, I don't remember seeing the actual person.

MR. PICKETT: On that basis we object to the witness even looking at it. It's not in evidence and he can't authenticate it.

Q. You could continue.

A. The second photograph which shows a scalp with stitches in it shows active blood clot around the wound. Yeah, I do recognize that as --

Q. Do you recognize that from seeing it in your clinical practice?

A. Yes, I saw that. That's what he looked like when he first came, similar to that.

MR. PICKETT: Just for the record you're referring to the second photograph?

THE WITNESS: The one with the stitches.

MR. PICKETT: The one on the bottom?

THE WITNESS: Yes, it's the one to the right this way. I had it turned upside down. (Indicating.)

MR. PICKETT: If we orient the exhibit so the exhibit sticker is on the bottom then it's

the photograph on the right that you recognize?

THE WITNESS: Yes, that's what I saw.

Q. Okay. How about Number 2?

A. Exhibit Number 2 shows a stitched laceration of the scalp that is a picture of Michael Newcomb.

Q. Is that an accurate representation of how it looked to you when you saw him?

A. Yes, that's exactly how it looked.

Q. All right. Using this pointer here if you could show that to the jury now and describe the injury that he suffered. Or what you treated him for when he came in?

A. This is what it looked like after he healed, he had an upside down horseshoe laceration. You could see that's a fairly large laceration. The stitched had been removed. There's still a scab there from the healing of the laceration. That's the size of the lesion.

Q. Now, Number 1 right here you said -- we're going to show this to the jury and we'll get the foundation in later through Mr. Newcomb, so it's okay, don't worry about that. The one to the right is the one that you saw, and the one to the left is not how it appeared when you saw it?

A. Correct.
Q. Just using the one to the right, describe that?
MR. PICKETT: As to both of these continue our previous objections.
A. This is what it looked like when he first appeared at the office. It's a dirtier wound with scab that's still present around the laceration. Stitches are still in place in this picture.
Q. Thank you. Did he give you an idea about how this incident occurred?
A. Well, he told me he had gotten -- driven his truck to this place where he had to unload it. He was --
MR. PICKETT: I'm going to object to the hearsay as to what he may have told him how this happened.
Q. You could go ahead.
A. My understanding is he said he was standing by the end of the truck where it was being unloaded. Somehow he was hit by the fork truck and got knocked into the truck itself and sustained this laceration.
Q. Based on Mr. Newcomb's condition, what did you do for him over the course of your treatment for this particular injury here in the short term?

Let's talk about the short term.
A. Well, initially I managed the wound, made sure it was healing. After the proper amount of time we took the stitches out. But it was not acting like a normal wound. He continued to drain fluid. He had some really unusual symptoms, swelling in his left eye, fullness in his ear, I think he had like pain that was not usual. Most patients like that don't have that much pain. He was having severe headaches. He had to have narcotics to control the pain. It wasn't acting like just a scalp laceration.
Q. Did you send him out to a specialist because of continued problems?
A. At that point because of ear problems we sent him to Dr. Azeredo who is an otolaryngologist at Geisinger right down the street.
Q. Tell us what an otolaryngologist is?
A. That's an ENT specialist.
Q. What's an ENT specialist?
A. One who specializes in the diseases of the ear, nose, and throat. And they're surgeons, they can operate, they also treat ear, nose, and throat problems medically.
Q. When you say diseases, does that also

encompass -- do you mean injuries to the ear, nose, and throat?

A. That would include traumatic injuries as well.

Q. So he went to go see Dr. Azeredo, is that right?

A. That's correct.

Q. That's at Geisinger?

A. Geisinger Medical Center.

Q. Big medical center here in Danville, is that right?

A. Yes.

Q. Did Dr. Azeredo, did he send you copies of the records, his clinical records after he saw Dr. -- after he saw Mr. Newcomb?

A. Yes, I would get reports from Dr. Azeredo as what his treatment was.

Q. Did you keep up with those reports?

A. Yes.

Q. Was that part of -- part and parcel of your treatment with Mr. Newcomb?

A. Yeah, it was very important because, you know, I wasn't sure exactly what was going on. So I needed help from my specialist colleagues to try to sort out what was the problem. So I would depend

heavily on what his opinion was.
Q. And in the practice of your medicine is that something you do on a regular basis, rely upon the reports of experts they supply to you?
MR. PICKETT: Objection, leading.
Q. For the treatment of the patients?
MR. PICKETT: Object to leading.
A. I can answer?
Q. Yes.
A. Yeah. One of the hallmarks of our specialty is we look at ourselves as family doctors, kind of like the general overseeing the whole battlefield. And a lot of times we need specialists to help us do artillery or whatever, to help fight disease. So, yeah, that's what we do, we send them to different subspecialists to get their opinion. And then we kind of coordinate everything, make sure everything is taken care of and nobody drops the ball because they think somebody else is doing it. So I do that routinely. It takes a lot of my time to read reports from specialists.
Q. How did these reports come to you, were they handwritten, from a computer, what kind?
A. They get faxed to us. Geisinger has an electronic medical record. I have access to that, I

could go in and get the electronic records. But it's easier for our system to have it faxed and scanned into our records.

Q. What was the course of treatment for Mr. Newcomb once you realized that he was still having trouble and you referred him to Dr. Azeredo. What course of treatment did he undergo then by the specialist to whom you referred him?

A. Well, he had several CTs, MRIs. Finally they discovered there was a crack in the bone in the middle ear, the roof of the middle ear bone was cracked. They had to repair it. He actually had what's called a CSF leak.

Q. What is that?

A. The fluid that surrounds the brain -- the brain is encased in fluid, and if there's a tear and a crack in the bone it actually could come outside, which is what was happening to Mr. Newcomb. It came into the middle ear and was stopped by the tympanic membrane, the eardrum, and that had to be fixed.

Q. What's the danger of having a crack in your skull causing brain fluid to leak down into it?

MR. PICKETT: I'm going to object to the question in that it's misleading and it assumes facts not in evidence. And to the extent this goes

beyond Dr. Eckel's qualification as a family doctor. He has testified that he had to refer him to Dr. Azeredo for these type of assessments. So I believe this is probably outside his area of expertise.

THE WITNESS: Well, that's ridiculous. It's not outside of my area of experience. It doesn't take any specialist -- you know, anybody with a medical degree knows that leaking brain fluid causes problems, one of which is meningitis, which is amazing that this guy got never got meningitis. But be that as it may --

Q. Let's just back up.

A. That's one of the complications.

Q. Are you qualified to answer that question?

A. Yes, I could answer that question. Based on my years of experience in treating patients and leaking brain fluid -- I mean, I'm stumbling here because I can't believe you just said that. But anyway.

Yeah, leaking brain fluid from a patient's brain is a very dangerous thing. You have a communication from the outside of the body which has skin and lots of germs right into your brain which is a sterile environment. So it's easy for

bacteria to get in and infect that, and this guy had it for weeks.

Q. Infect the brain?

A. Infect the brain. You could infect the lining of the brain, meningitis, you could infect the brain itself. You can have an abscess, encephalitis. You know, it just -- it's traumatizing to me to think how long it took us to figure out what was going on with this guy. I wish we could have done it sooner. It was just difficult because the initial CAT scans were read as normal, they didn't show the fracture, which sometimes can happen with a hairline fracture.

But eventually we were able to find out. And it was a difficult situation. You have leaking fluid, you hope it stops, sometimes it does, sometimes the crack will seal itself and the body will heal. You don't want to operate on there if you could help it.

Q. How was the --

A. Because the operation itself has risk. So we were in that kind of decision, and obviously I'll defer to Dr. Azeredo about that. But eventually the decision was made to do the surgery. And they had to cut out part of his brain, seal the crack, and

then hope that the wound would heal and the leak would stop, which eventually it did. It took several weeks after the surgery before it did.

Q. What was the test that finally was able to show that he had brain fluid in his inner ear?

A. I'll defer to Dr. Azeredo about that. You know, spinal fluid is different than other serous fluid and they can test for sugar content and things to be able to tell exactly what type of fluid it was.

MR. HELMS: I'm going to mark Exhibit 3, and this is for demonstrative purposes. If you could hand me that illustration.

MR. PICKETT: We're going to object to Exhibit 3 on the basis we just got this also about 45 minutes ago.

MR. HELMS: It's demonstrative purposes. I don't have to present it to you up until the time of trial if I don't have to.

MR. PICKETT: Well, since this is being taken for trial, I would argue we should have been provided it prior to the deposition, at least more than 45 minutes into the testimony.

MR. HELMS: Okay.

Q. Before you show that to the jury, are you

familiar with the anatomy of the place where Mr. Newcomb had his injury inside his --

A. Yes, somewhat.

Q. Is that a fair and accurate representation?

A. Yes, this is a standard cutaway frontal section of skull involving the ear.

Q. Basically your understanding of reviewing Dr. Azeredo's records and your years of experience and knowledge as a family treating physician, would this illustration help you describe to the jury the anatomy that was injured?

A. Yes, it's a very good picture of what happened.

Q. You could use this pointer if you need to show that to the jury.

MR. PICKETT: Again, I'm going to object. Dr. Eckel just testified he was somewhat familiar with the injury and would defer to Dr. Azeredo. I think Dr. Azeredo would be the better witness to discuss this particular injury. So if we're going to talk about this particular injury for Mr. Newcomb to that extent I would object to have Dr. Eckel testifying about that. If we're talking about general anatomy, I'm sure Dr. Eckel is qualified to talk about that.

A. That's all I'm talking about, is the anatomy. So the anatomy here of the middle ear, we've got the inner ear, which is your hearing mechanism, has the cochlea and nerves, the acoustic nerve that helps you hear. And here you have the bones of the middle ear that translate pressure airwaves that pulsate up against the tympanic membrane, the eardrum. And they make the bones of the middle ear, which are the smallest ears of the body -- smallest bones in the body. They make them pulsate and set up a fluid wave here in the circular window and the cochlea.

Now, in this space called the middle ear, it's surrounded by bone. And at the top you have the tegmentum of the middle ear. And it sits right at the base of the brain here. And apparently his injury was right here. (Indicating.)

MR. PICKETT: Again, I'm going to object to Dr. Eckel testifying about where the injury was in that he does not have direct knowledge of it.

THE WITNESS: Well, I do based on the operative report.

MR. PICKETT: And, again, that would be hearsay. And I'm going to ask that Dr. Azeredo

would be the proper witness for that.

Q. You could continue.

A. So based on my knowledge of what the report said, and, you know, I rely on these things all the time. So I was not in the operating room, I did not see this, but based on what the consultant's report said, this bone was apparently cracked. There was encephalocele, which meant part of the brain tissue was down through this crack.

Neurosurgeon, Dr. Toms, had to get involved with the surgery to cut away the part of the brain, and Dr. Azeredo sealed this part to stop the fluid leak into the middle ear which was bulging the eardrum out.

Q. Okay. How did Mr. Newcomb do after the surgery?

A. Well, it took some time. It continued to leak as I remember for a few weeks after. But eventually it sealed and he plateaued and is where he is today.

Q. All right. And you've treated and seen Mr. Newcomb a number of times since then, is that right?

A. Yes, I have.

Q. Okay. In preparation for this case, like I said, you've prepared a couple of different reports,

and as I said earlier I'm not going to go through all 40 some office notes, but based upon that I'm going to ask you a series of questions, and I'm going to ask for your opinion for you to give to the jury. All these need to be within a reasonable degree of medical probability, that it's more likely than not. Is that fair enough?

A. Yes.

Q. Can you do that?

A. I can.

Q. And I'm going to ask you some of your opinions about Mr. Newcomb since then. Can you tell us in your opinion what are, and this would be number 4 on the previous report, what are the injuries that Mr. Newcomb suffered as a result of this blow to the head?

A. Well, it was my and is my opinion to a reasonable degree of medical certainty that the following diagnoses were a result of the injury that he sustained on June 20, 2013: He had a fracture of the left tegmen with an encephalocele, and CSF leak as I just referred to.

Q. Tegmen, is that the bone --

A. Tegmen is the top roof bone of the middle ear.

Q. Inside the skull?
A. Inside the skull. And that's the part that cracked and the brain tissue herniated through it.
Q. Is that the encephalocele?
A. Yes, encephalo means brain and cele is the crack through.
MR. PICKETT: For the record we will, excuse me, object on the same basis we've previously stated.
A. And when that bone is cracked and meninges is torn it allows that fluid to leak through and that's what was causing his symptoms. So that was the one injury that he had. That was repaired by the craniotomy. And as I said before according to operative report part of his brain tissue had to be cut away.
Q. Craniotomy, what is that?
A. Craniotomy is when you cut through the skull bone to get into the brain cavity to treat whatever you're treating.
Q. Does Mr. Newcomb, does he have like a metal plate in his head right now, or is it --
A. He's got a scar on the scalp. I'm not aware of any metal plate.
Q. So they were able to replace whatever they

had to cut away?
A. Usually you put the bone back in place.
Q. Okay. I got you.
A. Secondly he had a -- when you have this kind of injury you could also damage the brain tissue itself, it's call a traumatic brain injury. We hear about it on the news all the time with football players and other people that get concussions. And as a result he had -- he exhibited symptoms of traumatic brain injury. He had a definite change in his personality, his emotions, his thinking.
Q. Have you treated people over the course of your 40 years of practice --
A. Oh, yeah.
Q. With that brain --
A. I've seen it a lot. I've seen it in athletes, I've seen it in people in car accidents. It's a sad thing. It's a lot more serious than what we used to think. That's why we do so much now with kids and concussions. We have whole new protocols now about how they can play sports after a concussion.
Q. Based on your experience of Mr. Newcomb before this incident and after the incident and

based on what he's told you it's affected this brain injury, how it's affected him, what are some of the symptoms that he's exhibiting now, problems he's having now from this brain injury?

A. Well, he has problems concentrating. He can't think as well as he used to. He has lost a lot of emotional control. He says things that are inappropriate sometimes. He yells at people.

When you have an injury like this it's difficult to live with. It's hard to -- it's hard to see in somebody that you love -- soldiers get it from trauma, battlefield injuries. I've treated a number of patients over the years with this, and unfortunately it tears families apart because most families can't handle it and leave.

Q. Has it been tough on the Newcombs?

A. It has.

Q. What have you observed as their family physician?

A. It has been -- his wife has told me it's been difficult at times.

MR. PICKETT: Object to the hearsay.

Q. You could go ahead. Is Mrs. Newcomb your patient?

A. Mrs. Newcomb is my patient. And she has

told me it's difficult for her at home and because he sits on the couch and yells at everybody.

Q. Is what she tells you important of your overall care and treatment of Mr. Newcomb?

A. Yes. Yeah, I treat the family and I get input from several of the family members. So anyway he's had those problems. He's had other injuries as well. He has some decreased hearing in the left ear, some vision difficulty, blurred vision. He has chronic post-traumatic migraine headache that he's getting botulinum toxin for, Botox injections, have helped somewhat. He needs the narcotics to control his pain. He's had some balance issues with damage to the left middle ear and the brain. He's -- the arthritis that was in his neck is probably worsened because of the injury.

Q. When you say worsened --

A. More pain.

Q. He had problems beforehand?

A. He had arthritis before.

Q. But as has this type of injury, has it exacerbated and aggravated, made worse the pre-existing condition?

A. Yes.

MR. PICKETT: Objection to leading.

Q. Was that a condition that existed prior to this incident?

A. Yeah. He had a, as I testified earlier, he had arthritis in his neck and I've seen him before, it would flare up on occasion. But it's my opinion to a reasonable degree of medical certainty that that arthritis was made worse by this injury because he's got more pain now in his neck, much more severe actually than it was before.

Q. Based on years of treating people in car wrecks and different types of trauma, does a blow to the head, does that -- can that aggravate and make worse arthritis in the neck?

MR. PICKETT: Objection to leading.

A. Yes, it can.

Q. And how would that do it?

A. Just the jarring of the bones just kind of stretches ligaments. It disrupts some of the bony juxtaposition or adjustments, alignments of the bones and it causes inflammation, which can precipitate or aggravate the ongoing arthritis that's already in the neck. It just makes things worse.

Q. Doctor, do you have an opinion within a reasonable degree of medical certainty of whether or

not these conditions you've talked about with Mr. Newcomb are permanent?

A. It's my opinion, again, to a reasonable degree of medical certainty, that these problems will persist for Mr. Newcomb for the rest of his life.

Q. You talk about narcotics and how Mr. Newcomb has to come in every 30 days now, is that right?

A. That's correct.

Q. And why do you handle it like that?

A. Well, narcotics are dangerous. They're controlled substances. They relieve pain, but they also have a lot of side effects, one of which is addiction. We've discussed this with Mr. Newcomb. Unfortunately his pain is to the point that this is the only thing that helps him. So what I do with my patients who are on chronic narcotics is I generally have a written drug contract, and patients know they can only get these controlled substances from me.

Q. Let me -- when you say you have a written drug contract, explain that to the jury, what do you mean --

A. Either written or verbal. I talk to the patient and I tell them, you know, you're going to

get narcotics from me, you can only get them from me, you cannot get them from any other doctor. That prevents doctor shopping and taking other controlled substances that I don't know about. Fortunately in Pennsylvania we recently just got a prescription drug monitoring program established. And now we can, and by law, we have to when we prescribe them, every time we prescribe them, we have to go into the database and check and make sure they have not received them from any other physician. So it takes extra work, plus, it's my opinion that it's better medical care to keep close control over these patients because the risk of addiction is real, and a lot of times there is an event called an unintended overdose where you take these drugs at the prescribed doses the correct way and it still can suppress your respirations and cause you to die, stop breathing. So they're dangerous, and that's my policy that I see these patients every month.

Q. I guess during the course of your practice do you see some patients that might try to abuse these drugs?

A. I have, yes.

Q. Based on your experience of Mr. Newcomb since 2002 up through today does he give you any

indication or symptoms that he is abusing these narcotics in any kind of way?

A. No, I don't think he's abusing them.

Q. Are they absolutely necessary for him to function during the course of the day?

A. They are absolutely necessary for him to function. I wish they weren't, but they are.

Q. All right. Moving on. There have been some questions about whether or not Mr. Newcomb could return to work. And I think even at one point it was suggested that Mr. Newcomb could do the work of a cleaner, a team member at Arby's, a cashier, sandwich maker, crew member, front desk clerk, things such as that?

A. That's correct.

Q. Do you remember that?

A. The insurance company wanted him to get back to work.

MR. HELMS: Okay. We'll both just say we can't talk about the insurance and we're going to edit out all this part, so let's start over. Is that fair enough?

MR. PICKETT: Yeah, we don't want that word.

THE WITNESS: That's who told him.

MR. HELMS: We know that.

THE WITNESS: Put that in the jury. I'm ticked off about this, jury, this guy should never go back to work.

MR. HELMS: We're back on the legal record now.

BY MR. HELMS:

Q. During the course of your treatment of Mr. Newcomb at some point there's a number of jobs suggested that he could do?

A. Yes. Someone suggested that he could go back to work as a fast food operator, whatever. The problem is with his injury, with traumatic brain injury or any brain syndrome you lose a lot of your frontal lobe function just from the trauma of the brain. You lose some soft subtle social graces that we all have and know and need to get along with people. He's lost a lot of that.

It's my opinion to a reasonable degree of medical certainty that he will -- he is totally and permanently disabled. No person is going to hire him. If they hire him he's not going to be able to stay in a job because he's going to lose his temper, he's not going to get along with his coworkers or customers and he'll be fired. It's

just not going to work.
Q. Mr. Newcomb at the time of this incident was a long haul truck driver, can he do that?
A. Absolutely not.
Q. What's the dangers of him driving a big truck?
A. Your truck you're driving you need instant reflexes. I would not -- he should not be driving in my opinion.
Q. Should not be driving at all, period?
A. Should not be driving, and I've told him that.
Q. Does he sometimes cheat and drive to your knowledge?
A. I'm not going to answer that question.
Q. What would be the limitations, and this is number 6 in your report, that you would think would be fitting for Mr. Newcomb right now?
A. Well, I stated that his limitations should include no driving, he should avoid all stressful environments, because stress makes his condition worse, so that would include personal stress, job related stress, work related performance goals, production goals, piece work. So anything that adds stress to him, he's not going to do well at. He's

going to lose his temper, he's going to get more nervous, and he's not going to be able to function. He can't function in a capacity where multitasking is required. He's not going to be able to relate well to coworkers or to the general public. And he probably should have a weight restriction of around 20, 25 pounds at most.

Q. Doctor, of course we always want the best outcome of any kind of medical treatment, we know sometimes that doesn't happen. But in your opinion could you tell the jury what would be the best scenario for Mr. Newcomb going forward from this point based on your examination and treatment of him over the years?

A. My opinion to a reasonable degree of medical certainty is that he's plateaued, he's not going to get better. These patients do not improve. I've just never seen it in my 38 years of medicine. Unfortunately he's stuck where he is and he's probably going to need narcotics for the rest of his life. His life has been changed forever. You know, he was fine, he was functioning before the accident. Since the accident he's reduced to -- well, I'll give you an example. He was trying to work around the house, he goes and he cuts his finger almost off

because he couldn't react fast enough, didn't have the coordination, didn't have the multitasking to be able to handle a power saw.

Q. And you treated him for that, is that right?

A. Well, I saw him afterward. He had to go to the ER and went to the operating room to get some ligaments fixed with that injury. He just can't work.

Q. How about medications into the future, in your opinion what's he going to need?

A. Well, he's going to need probably the Botox. He's going to need -- because that does help him. He's going to need narcotics.

Q. In your opinion, medically, your research, your experience with your patients, does the Botox tend to help people who have chronic headaches and migraines?

A. It can, yes, not everybody.

Q. Has it provided him some relief?

A. It has given him some relief, yes.

Q. In your position as a family physician, if a medication or a treatment works, you go with it?

MR. PICKETT: Objection, leading.

A. Well, again, I defer to my subspecialist

colleagues. I refer him to neurology for these headaches. And the particular neurologist that he's seeing has expertise in Botox. And she has been giving him the shots and they work and I say sure, keep it up.

Q. She's a neurologist from Geisinger, is that correct?

A. Yes.

Q. Dr. Kelley?

A. Dr. Kelley.

Q. And you've reviewed her records also?

A. Yes.

Q. In your opinion is Botox a legitimate form of therapy for Mr. -- medically necessary therapy for Mr. Newcomb?

A. Yes. It's an FDA approved treatment for this problem and it works for him. So I certainly agree with continuing it.

Q. Has Mr. Newcomb as a patient, has he complied with your medical advice, has he done what you've asked him to do to try to get better?

A. Yeah, he has generally done everything that I've asked him to do.

Q. Are there some things he hadn't done, smoking I guess?

A. Smoking is one. Yeah, he -- I'm just thinking here, he wants to get back to work, he doesn't want to be sitting at home on a couch. And I'm trying to -- yeah, there's nothing that I could think of that he -- that I have suggested that he was not willing to do. He's gone to all the specialists that I referred him to. So, you know --

Q. That was going to be one of my last questions, has he exhibited a genuine desire to get better?

MR. PICKETT: Objection leading.

A. Yeah, absolutely. Well, I can just --

Q. Let me back up and ask you this. You have patients that sometimes appear to you not to want to get back to work?

A. Yeah, I have had a few what we call malingerers or just feel better being disabled.

Q. Yeah.

A. Not too many. In my experience most patients really do want to work. This is absolutely one who wants to work. He has been a hard worker all his life and as a man that's his thing, he likes working. As I said, he was trying to build onto his house doing a project around the house and his son was helping him and he injured himself. So he has a

hard time just sitting at home doing nothing.

Q. Would you continue to be Mr. Newcomb's doctor?

A. Absolutely.

MR. HELMS: Doctor, thank you very much. Mr. Pickett is going to have some questions for you.

MR. PICKETT: Do we want to take a break before I do these, are or are we good?

MR. HELMS: It's up to the doctor.

THE WITNESS: I'm fine.

MR. PICKETT: Court reporter?

THE WITNESS: I'll take a drink.

(Discussion held off the record.)

MR. PICKETT: Back on.

* * * *

CROSS EXAMINATION

* * * *

BY MR. PICKETT:

Q. Dr. Eckel, you saw the wound that Mr. Eckel had, correct?

A. Mr. Newcomb, yes.

Q. I'm sorry, Mr. Newcomb had. And that injury was to the left side of his head?

A. That's correct.

Q. And do you want to look at your notes to be sure?
A. Yes.
Q. Well, maybe not from the photographs, but do you have indications in your records of it being on the left or right side?
A. Do you want me to look?
Q. Yes, sir.
A. Yes, it was the left side.
Q. So you conferred with your notes and we're certain absolutely positively this was on the left side of his head?
A. Yeah.
Q. So you're sure about that. The -- if you look at your records you treated him since back as early as I believe you said 2002, is that correct?
A. Yes.
Q. Do you remember him having an occasion or complaints of dizziness back as early as 2002?
A. Do I remember it, no.
Q. Can you refer to your records and maybe look at the entry from his visit on June 4 of 2002, see if that can refresh your recollection?
A. Yes.
Q. He did have dizziness in June of 2002?

A. He apparently said he became suddenly dizzy at work.

Q. Okay.

A. On June 4, 2002.

Q. Then a couple of years later in treating him he had a head injury in 2004, you treated him, if you look at the record, on November 1 of 2004.

A. Yes.

Q. And the head injury that he had in 2004, late 2004, that injury was also to the left side of his head, correct?

A. He had a laceration of his left forehead with seven or eight subcuticular sutures at that time.

Q. And there was actually a problem with one of these sutures that migrated and had to be removed later on. It didn't stay where it was supposed to be, did it? I believe if you would look at the record on 11/04 of 2004.

A. That's correct.

Q. And then the stitch was actually removed about a week later, the suture was removed about a week later on 11/11/04.

A. That is correct.

Q. And when we say a suture migrates, that

means where it's originally placed it doesn't stay there, but it moves through the body?

A. I'm not sure if it migrated. But apparently the one suture was tied into the subcuticular sutures, the knot got tied in there. The one is dissolvable, the other one has to be removed. It couldn't be removed so they both had to be cut out.

Q. Did you remove those stitches?

A. Apparently, yes.

Q. But you weren't able to remove one of the stitches --

A. Well, the one that was to be removed couldn't be removed because it got tied into the subcuticular suture that dissolved. So eventually we did remove it.

Q. The stitches basically got wrapped up with each other?

A. Yes.

Q. In layman's words?

A. Yes.

Q. So you had to remove it later than you hoped to?

A. Yes.

Q. From the accident that he had in 2004 he

had an injury to his eye as well?
A. Apparently there was some soft tissue injury around the right eye.
Q. Okay. And it was your opinion at that time that the -- this injury was probably caused by his head impacting the steering wheel of his truck?
A. Did I say that?
Q. If you look at your record on November 11, 2004.
A. That's what it states in the medical record, yes.
Q. And as a result of that injury he had headaches, correct?
A. Yes, I refer to headaches and I had him come back so see if they were gone.
Q. You saw him subsequent to that on January the 10th of 2005. Can you look at that office note?
A. Yes.
Q. And he still had -- at that time still had some numbness in his forehead?
A. The note reads, he comes in for re-check. He smokes about a pack of cigarettes a day. Again, he was told about not smoking. He keeps trying to stop. He had some numbness of his forehead two inches above or behind his hairline. Used to be

about four to five inches behind the hairline. So it was improving, still has constant headache.

Q. And the side of the head we're talking about there is again on the left side, correct?

A. It doesn't say which side it is.

Q. Okay. If we look to the initial injury back in November it was on the left side?

A. Left forehead.

Q. So it's the same area where --

A. I assume, yes.

Q. As far as the headaches, there was some discussion in his January 2005 visit that they may be being caused by the painkillers he was taking, is that correct?

A. At that time I stated in the record that he has to see if he could stay off the pain medicine to see if it goes away, the headaches.

Q. He told you he still had a constant headache and he thought it might be due the pain medication?

A. Sometimes you could get a rebound phenomenon with pain medication which actually causes headaches.

Q. Before we talk about the headaches and the painkillers, may I refer you to one more note

further down the line, July 6 of 2010. Have you got that one?

A. Yes.

Q. And, again, this is before the accident that we're here talking about today by about three years. In July of 2010 he told you he was having a lot of problems at home, didn't he?

A. Correct.

Q. And that his in-laws had moved in and he was feeling left out?

A. That's correct.

Q. As far as painkillers go he started taking Vicodin, this is June 22, 2004, if you want to refer to that note.

A. Yes.

Q. Back in June of 2004 he had fallen out of his truck and injured his left knee, is that correct?

A. Yes, he had an old knee injury and he fell out of his truck. I saw him on the 22nd. He said he fell out about 11 days previous to that. He was given a prescription for Vicodin, which is Hydrocodone, 5 milligrams, with 500 milligrams of Tylenol.

Q. Earlier we were talking about narcotics,

Vicodin is a narcotic, is it not?
A. Vicodin is a controlled narcotic, yes.
Q. He took that -- you first prescribed it in June of 2004. He continued to take it, it was renewed in -- on November 2, 2004, is that correct?
A. Yes.
Q. And continued to take it up until January 10 of 2005 when there was concern it was causing him headaches?
A. Yes.
Q. Subsequently in 2009 he started having pain with his neck, cervical pain you talked about earlier?
A. He would have that off and on, yes.
Q. Well, June 1 of 2009 he began taking Percocet for that pain, correct?
A. That's correct.
Q. And Percocet is also a narcotic?
A. Percocet is Oxycodone and it is a controlled narcotic.
Q. Okay. He was renewed for his Percocet in -- you first prescribed it in June, renewed in August and October of '09.
A. He had several renewals for Percocet, yes.
Q. But he was actually renewed two months

later in August --
A. He had another prescription June 15.
Q. So we had the first one in June, another one June 15, one on August the 6th, and another one on October 16, all in October 2009?
A. Correct, 60 tablets, no refills.
Q. He missed a couple of appointments with you in December of '09, the 17th and the 21st?
A. Well, he canceled and rescheduled, yes.
Q. And ended up coming back, his next appointment was January of 2010, and he got another refill for Percocet?
A. January 4, 2010 he got 60 tablets, no refills.
Q. Got another refill in February, the very next month?
A. Correct.
Q. For Percocet he got another refill in April for Percocet?
A. Correct.
Q. He got another refill in May for Percocet?
A. Correct.
Q. He got Percocet renewals in September and December of 2010 as well?
A. September -- August, September, November,

December 2010.

Q. September, October, November, and December?

A. September, November, December.

Q. Of 2010?

A. Correct.

Q. Okay. So that's one, two, three, four, five -- seven of the 12 months in 2010 he got refills for Percocet?

A. I count nine.

Q. Nine. Nine out of the 12 months he got refills for Percocet. And if we look at 2011 he is still taking Percocet and he was prescribed Percocet in January, March, April, and October. Are there any other months?

A. January, February, April, October.

Q. Of 20 --

A. I'm referring -- can I show the jury this?

Q. Sure.

A. I'm referring to his paper chart. This is before our electronic records. I have a medication list which I try to keep up, and every time he gets a prescription I write it in here.

Q. And he has gotten prescriptions for Percocet in the year 2011, how many months do you show?

A. January 3, February 10, April 29, October 13.

Q. So four months that year?

A. Correct.

Q. And then in 2012 he got, my records that I have copies of show May and August?

A. This has one entry, January 16, 2012, this was around our conversion to the EMR, so the others might be in the electronic record.

Q. If you look at your office records on May and August of 2012, those would be May 18?

A. Okay.

Q. Of 2012.

A. So for the jury now I'm looking at his electronic medical record, and we have a thing called an RX Manager that should give me a history -- should show me all the dates for all the refills. The note says, just refill medications on May 18, 2012.

Q. Okay. And in May of 2012 he got a three month supply of Percocet?

A. That may be, yes.

Q. Three months later on August 6 of 2012 he got another renewal or refill for Percocet?

A. August the 6th.

Q. Yes.
A. He got prescription ready tablets, no refill.
Q. At that time he was being prescribed about 40 tablets per month, correct?
A. Well, somewhere around 30. The script on August 6 for 80 tablets lasted until October 22. So that was a little bit over 2 months.
Q. A little bit over two months for 80 tablets?
A. Yes.
Q. So that's a little more than over a tablet a day?
A. Yes, which is not that high of a dose.
(Telephone call interrupted the deposition.)
THE WITNESS: My racquetball partner.
Q. So if you saw him on, if you look at your note, from March the 15th of 2013.
A. March 15?
Q. March 15, 2013.
A. Give me that date again please.
Q. March 15 of 2013.
A. Oh, I'm sorry.
Q. Okay. You made a note in your record at

that time that what you were treating him for was, quote, long term drug monitoring?

A. No, that term, when I use that term that's a code word for me that I am monitoring his body's reaction to drug use, not just narcotics, but any kind of medicine.

Q. Okay.

A. So like a lot of medicines affect the liver and kidneys and things like that, so I have to check kidney function, liver function and that's what that means.

Q. But in fact started taking Vicodin in 2004, started Percocet in 2009, was taking Percocet daily if not more than once daily throughout 2009, '10, '11, '12. So the long term drug that you were monitoring for him was a narcotic, correct?

A. No, actually. I mean, that dose -- you know, I don't like narcotics. I don't like patients on it, there's just so many problems with them. But that's a fairly low dose. Actually what I was monitoring was his Zocor, Simvastatin, for his heart disease. That can affect the liver and you have to get liver enzymes and other blood tests. That's what that was for.

Q. Narcotics can affect the liver, can't they?

A. Yeah, but not at that dose in my experience.
Q. Narcotics can cause headaches, can't they?
A. They can. You could get rebound headaches from narcotics, any kind of pain pill.
Q. Narcotics can cause dizziness, can they not?
A. They can.
Q. They can cause mood changes?
A. I mean, I always tell patients you die from any drug, any drug can cause any symptom.
Q. But a narcotic specifically can cause a mood change, can it not?
A. It can.
Q. Okay.
A. That's -- you know, it can.
Q. After this accident instead of the Percocet he started taking OxyContin and Oxycodone, correct?
A. Correct.
Q. Initially. And then more recently he is now taking morphine?
A. Correct.
Q. His morphine prescription amounts to four doses a day?
A. Currently -- let me review my record. He's

on an extended release morphine sulfate 60 milligrams. He takes one of those every 12 hours. And he's on an immediate release preparation that he can take for breakthrough pain. And he's on 15 milligram tablets of the immediate release morphine sulphate, and he gets 60 of those a month. So he's taking on average two of those a day.

Q. Two of the immediate release and two of the extended release?

A. Correct.

Q. So a total of four morphine tablets a day?

A. Correct.

Q. That's a pretty high dosage of morphine?

A. That's a fairly high dose, it's kind of a middle dose.

Q. When he was taking Oxycodone, and if you need to refer to a record it's August 19, 2013, he was taking Oxycodone at least four to five times a day and sometimes seven times a day?

A. That was on just flare ups of his osteoarthritis of his neck pain, not usually.

Q. But I'm talking when he was taking Oxycodone and OxyContin in August of 2013, was that for his neck pain?

A. Oh, August of -- I thought you were

referring to before. After the accident?
Q. Yes, sir.
A. It might be, do you want me to check the records?
Q. Yes, if you want to, I would like for you to be accurate, August the 19th of 2013?
A. At that time the record states that his medication he was taking four to five times a day, sometimes seven times a day, Oxycodone 10 milligrams. Wasn't abusing it. He said his scale -- his pain on a scale of 0 to 10 he said was a 10.
Q. That's a good bit of Oxycodone for him to be taking, is it not?
A. That's -- yeah, that's a moderate to high dose. With that much medication that's one reason why we switch a patient to a longer acting drug.
Q. And Oxycodone and OxyContin, those are also narcotics, correct?
A. Correct.
Q. And morphine is of course a narcotic?
A. Correct.
Q. All those narcotics, those are dangerous medications?
A. They are.

Q. That's why you have this contract with him and that's why you monitor their drug use?
A. Yes.
Q. One of the conditions is he is not supposed to drive?
A. That's my recommendation.
Q. That was I believe in the list of things, that was number one on your list as far as your recommendation, wasn't it?
A. That's a recommendation. And certainly on these medications you've got to be careful. The way we approach that medically because we're in such a litigious environment, is I always tell patients, if you're on a narcotic, do not drive. Some patients can drive safely on narcotics, it doesn't affect them to the point where it slows their reaction time. But I always tell patients, if you get in any kind of accident and the opposing attorney finds out that you have narcotics in your system, they'll fry you. So I always advise patients, never drive on these medications.
Q. Would it surprise you to know shortly before November 18, 2015 he drove all the way from here in Pennsylvania to south Georgia?
A. What year was this?

Q. In 2015, November 18, 2015?
A. Would it surprise me?
Q. Yes.
A. No, it would not surprise me.
Q. And why not?
A. Because I, how do I say this --
MR. HELMS: Sure, you could give your opinion.
A. Because that's Michael.
Q. But he's not supposed to be driving?
A. He's not supposed to be doing that.
Q. And if he did that and his wife was with him and she was available to drive but he just chose to drive, that's not something he's supposed to be doing is he?
A. Well, he's not. This guy is a whatever, 30 year truck driver, and I'm sure he's safer than most people on the road. But I would never -- you know, for reasons I've just said, I just don't think it's wise to put yourself in that position.
Q. Is there anything in the contract that you have with him that says he's not supposed to drive?
A. Not to my knowledge.
Q. Okay. But it's -- if he's taking a narcotic and he drives that is dangerous?

A. It could be dangerous. As I said, it's not dangerous for everybody. But I would not take that risk. If I was on those medications I would not do that I hope.

Q. And it is your opinion that he cannot or should not drive?

A. It is my opinion that he should not drive because if he's in an accident he'll be blamed whether it's his fault or not.

Q. It's like driving drunk?

A. Like driving drunk, yes. He's got a mind altering substance in his blood.

Q. The contract you said is sometimes written or sometimes verbal. Is the one with him written or verbal?

A. I can't find a written drug contract in his EMR, so I have to assume it's verbal. I don't know.

Q. He comes to see you basically on a monthly basis to get his morphine, is that correct?

A. Correct.

Q. And he told you that he needs the morphine because it helps him calm down?

A. Well, it's my understanding he needs it for his headaches and his neck pain.

Q. If you look at your office note from April

22, 2016?
A. Yes, I'm at that note.
Q. If you would look at the fifth paragraph I believe, it says, he needs to be on the medication which helps him calm down.
A. That's probably referring to the Citalopram, Lexapro that he's on. That's an antidepressant.
Q. What he's coming back for though, the plan at the bottom is to renew his morphine?
A. Uh-huh.
Q. Correct?
A. Yes.
Q. And the reference to the medication, that's not to the morphine?
A. No, that's the problem with reading these records after the fact or for litigation, things like this, no, it's nothing at all about that. I think it refers to he's -- we're treating like six different things here. At this trial we're only focused on the head injury and the narcotics. But as a result of the injury he got depressed. And he was placed on an antidepressant Citalopram, Lexapro, and that helps him focus, that helps him calm down.
Q. If you would look at the office note from

April 22, under the portion that says subjective, which is where you're talking with him and where we see the note about medication helps him calm down, is there any reference at all, and it's a full page of notes, is there any reference at all in that full page of notes about Lexapro?

A. Yes. Under the medication list if you look down at the bottom of that note, one of his medications is Lexapro, Citalopram, 20 milligrams daily. And I know that that medication is used to help people who are stressed, who are anxious.

Q. And you're looking at --

MR. HELMS: Hold on, hold on. Let him finish his answer.

A. And that is one of the reasons why I prescribe that medication. So I would not -- personally, I generally do not prescribe narcotics to help people calm down. So when I'm reading this note months later I know that I would have put a sentence in there, he needs to be on the medication, it helps him calm down, it refers more to the Lexapro than it does to the narcotic.

Q. Again, I'm going to ask you, the report from that day is actually a three page report. The first page is under the heading, subjective. Then

there's a second page that has, objective, assessment, and plan. And then there's a third page that has medications on it.

A. Okay. It's all on one page here in the EMR.

Q. Under the heading subjective it's a full page of notes that you've taken for your meeting with him. And subjective is basically a discussion that you have with him, correct?

A. Correct.

Q. And under the heading subjective is there any reference there to Lexapro? I'll tell you what we could do, Doctor, to shorten this.

A. Yes.

MR. PICKETT: Let's go off the record for a second.

THE VIDEOGRAPHER: The time is 10:44. We are going off the video record.

(Discussion held off the record.)

THE VIDEOGRAPHER: The time is 10:46. We are back on the video record.

Q. Dr. Eckel, I am going to hand you what's been marked as Defendant Exhibit 1, which is a collective exhibit of printouts of your office notes from your visits with Mr. Newcomb from April 2016

through December of 2016. Is that correct?
A. Correct.
Q. Can you review those to make sure that is what those are?
A. Okay.
Q. And these are the hard copies of what you've been referring to in electronic fashion --
A. That's correct.
Q. And these are recordings of your office notes as you have met with Mr. Newcomb during those months of April through December 2016?
A. Yes.
Q. And under the subjective part of those reports that is the intake or the conversation that you had with Mr. Newcomb that you've recorded on each of those dates?
A. Right.
Q. And then we've also talked about other sections of each day for the medications, for the plan, for that sort of thing?
A. Yes.
Q. But those are true and correct copies of your records?
A. The subjective area is the historical part of the medical record you take history from the

patient.
Q. That's the conversation you have with him each day?
A. Correct.
Q. Those are true and correct copies of your records?
A. As far as I can tell, yes.
Q. Are you still providing long term pain medication management to Mr. Newcomb?
A. Yes, I am.
Q. And one of the medications that you're managing for him is morphine?
A. Yes.
Q. Just like you were doing pain medication for him back in March of 2013 before this accident and for years before that?
A. Yes, a little bit different now because the pain is worse and more intense. Before he did not need the medication every day. It was more flare ups.
Q. And these are more powerful narcotics he's taking?
A. More powerful.
Q. He has graduated from Vicodin to Percocet to OxyContin to Oxycodone and now to morphine?

MR. HELMS: Object to the form.

A. No. Actually Oxycodone, Hydrocodone basically are the same. That's kind of a mild narcotic, that's about as mild as you could get for episodic pain. Then he had this accident and now he's got constant pain. The Oxycodone is a long form -- the OxyContin was a long form of the Oxycodone, just extended release, so you take less tablets. And the morphine extended release is similar, and the reason for the change is he lost his coverage for the OxyContin, couldn't afford it to pay cash, so this is a cheaper medication.

Q. And, again --

A. And actually that's the only reason for the change because I prefer the other medication because it's abuse proof.

Q. And morphine is not abuse proof?

A. OxyContin has some features to it that prevent it from being abused.

Q. The injury that you saw him for shortly after -- or on June I guess the 24th of 2013, that injury was to the left side of his head?

A. Correct.

MR. PICKETT: That's all the questions I have.

* * * *

REDIRECT EXAMINATION

* * * *

BY MR. HELMS:

Q. Doctor, do you want take a short break? I must ask some follow up questions.

A. That's fine.

Q. You ready?

A. Yes.

Q. You were asked about some dizziness back in 2004 that Mr. Newcomb suffered.

A. Yes.

Q. Was that permanent or was that short term?

A. That was just short term. I really thought at that time, reviewing my records, I really thought that was an emotional situation he was going through.

Q. Back in 2004?

A. Back in 2004.

Q. Did that episode of dizziness cause him to lose any time from work?

A. If I recall in reviewing the record that dizziness was 2002.

Q. Okay. I'm sorry.

A. And that was he had just lost his job or

had stopped driving or something and emotionally it was a tough thing for him and he was going through a hard time then.

Q. Have any long term effects on his ability to work?

A. No, no, it was a temporary situation that resolved.

Q. That dizziness he suffered back in 2002, was that anything like the dizziness he suffers now?

A. No, completely different injury, completely different problem.

Q. Is it more -- is it worse now than it was in 2002?

MR. PICKETT: Objection, leading.

Q. Which was worse, 2002 or now?

A. Now. I mean, this was a different injury. This is totally different really.

Q. 2004, you were asked several questions about headaches he had in 2004 due to I think he hit his forehead on something?

A. Correct.

Q. And I take it it was a car wreck, he hit the steering wheel or hit the dashboard or something?

A. Yeah. I believe he was -- it was with a

truck, 18 wheeler I thought I saw, a truck accident. Back on November 1, 2004 he was in a truck accident Thursday morning at 3 a.m.

Q. Did those headaches cause him long term disability being out of work?

A. No. That's a good example. I mean, I said head injury at that time. That was a minor thing. Sometimes people do things like this, hit their head off the dashboard or whatever with no sequelae, have no brain --

Q. When you say sequelae?

A. No complications, no problems from it. They have some initial soft tissue injury, laceration, might even have some central nervous system, brain problems, thinking, confusion, memory problems, but they get better. And that usually happens short term. That apparently was this kind of situation. It was a minor concussion you could say. Actually not loss of consciousness, but you could still whack the brain and not lose consciousness but have some minor abnormalities.

That's why we're finding these things out in sports where you have some minor damage to the brain, maybe or maybe not loss of consciousness, but the brain is affected. That's why it's so

dangerous to put those kids back into play right away because the brain isn't working right and they can't recover. If they get hit again they can't recover and a second injury is much, much more dangerous.

So he recovered apparently from this injury. But the injury that we're talking about now from the accident of June --

Q. 2013.

A. 2013. That was much worse. And he hasn't recovered and he won't recover.

Q. Did you give Mr. Newcomb his D.O.T. physical so he could drive a truck?

A. Maybe initially. They've changed the law in Pennsylvania that now there's a special certification to do that I don't do them. I elected not to do that.

Q. Based on your yearly visits you saw him from 2002 to 2013. Did he ever have a condition that you felt would disqualify him from driving a long haul tractor trailer?

A. No. With the provision I told him not to drive when he was on the narcotics for his neck pain.

Q. Yeah, that was going to be my next question

too. The Percocet or the Vicodin he took for his neck and I think his knee pain over the years, did those, you were just prescribing those for his neck and knee pain, did that disqualify him in any kind of way in your opinion from driving a long haul truck?

A. Only from the fact that he shouldn't take it when he's driving because if he was in an accident it would be a problem.

Q. Did he ever indicate to you that he was taking those medications and driving a tractor trailer?

A. No. I think -- because I would ask him about it and he would give me the right answer and say no.

Q. There was a mention back in 2009 I think he suffered an injury to his right eye. I think it was 2009, some point right in there. Did that have any long term affect on his ability to work?

A. What is this injury we're talking about?

Q. He asked you about an injury to his right eye, it was in connection with a laceration to the forehead.

A. Oh, that was back in 2004.

Q. 2004.

A. Yeah. Well that injury, that was a question about ptosis, that means dropping of the eyelid, he had swelling of the right eye. But yeah, that was all temporary, he recovered from that.

Q. Did that in any way affect his ability to work or drive a long haul drive for the next nine years?

A. No, it did not affect his ability to drive. In fact, he did drive after that.

Q. We've been through the issue about the Percocet and the Vicodin and the morphine. There was a series of questions he asked you about this issue of calming down. Do you treat patients as a family physician for depression and agitation, do you see patients for that?

A. I see them every day. And as a matter of fact, that's one of the things I like to treat in family medicine, depression and anxiety.

Q. And do you prescribe medications that help them with that?

A. I do.

Q. Were you prescribing medications to treat Mr. Newcomb's depression and agitation?

A. I was.

Q. And what were those medications?

A. He was on Lexapro, 20 milligrams, which is an antidepressant. It's a member of the SSRI class which raises a chemical called serotonin. It raises those levels in the brain. It works for depression and works also for anxiety.

Q. Were those the medications that you were giving him for -- to help him calm down as opposed to morphine?

A. Yes. I would say that I would refer more to that. You know, narcotics can help calm you down too, but the Lexapro, that's why it was prescribed.

Q. You've treated a -- I'm sorry.

A. And I wouldn't -- somebody that was agitated or depressed or anxious, I would never give them narcotics to treat that. That's not a reason to do that. That's like killing a fly with a sledgehammer. You know, you would use something much safer that's not addicting like Lexapro.

Q. You've treated people here in Danville, coal country, who get injured and can't work, is that right?

A. Yes, I have.

Q. Men?

A. Men and women.

Q. How does that affect them generally when

they're no longer able to work and labor and earn a living?

A. Well, it's probably true the world over, but around here, you know, like most men they -- their thing is working and they want to provide for their family. And Michael is no exception, he wants to get back to work.

Q. Does that lead to depression if they can't get back to work?

A. Absolutely.

Q. In your opinion within a reasonable degree of medical probability based on being a family physician for all these years, has Mr. Newcomb's inability to work and labor led to his depression?

MR. PICKETT: Objection, leading.

A. Well, I can state clearly to a reasonable degree of medical certainty that this accident has seriously and permanently altered Michael Newcomb's life and he is not the man today that he was before the accident. And I would say most of that, it's not the physical stuff, it's the emotional fact that he cannot work any longer and provide for his family.

Q. As it relates to the depression?

A. As it relates to the depression and the

disability really, really the disability that he can't work.

Q. There was several times the question was emphasized about the injury to his -- was to the left side of his head. Did you ever see any records where Mr. Newcomb was complaining of increased pain to the right side of his head?

A. I can't recall.

Q. Would you find that unusual?

A. No.

Q. Did he ever complain of, you know, generalized -- I mean, specific pain as opposed to general headaches?

A. No, I mean, he had a headache encompassing the whole head. I mean, he wouldn't just limit it to the area on his scalp on the left side, sometimes it would just from the neck up hurt.

Q. Is there any question in your mind that his, the headaches that he suffers now after June of 2013 were caused by this incident, as a medical professional?

A. No. Certainly he had headaches before, and in that sense this accident has made those worse. But I think he has new headaches on top of it caused by this accident.

Q. And, Doctor, would you ever prescribe medication to Mr. Newcomb or any patient if you did not in your professional opinion believe they were absolutely medically necessary for his condition?

A. No, I would not.

MR. HELMS: Doctor, we appreciate it very much.

THE WITNESS: Thank you.

MR. HELMS: And it's snowing outside.

MR. PICKETT: I don't have anything else.

THE VIDEOGRAPHER: The time is 11:03. That concludes this video deposition.

(The deposition concluded at 11:03 a.m.)

_____, 2016

I hereby certify that the evidence and proceedings are contained fully and accurately in the notes taken by me of the testimony of the within witness who was duly sworn by me, and that this is a correct transcript of the same.

_____
Justine Starrick
Registered Professional Reporter
Notary Public